REPORT OF THE MIDWIFERY SERVICES REVIEW COMMITTEE

Tabled in the
Legislative Assembly of Alberta
by the
Hon. Stephen C. West
Minister Responsible for
Professions and Occupations

April 1992

Alberta
GOVERNMENT OF ALBERTA

January 17, 1992

Hon. Mr. R. S. (Dick) Fowler
Minister Responsible for
Professions & Occupations
319 Legislature Building
EDMONTON, Alberta
T5K 2B6

Dear Hon. Mr. Fowler:

Further to the Ministerial Order of September 17, 1991, made pursuant to Section 4 of the Department of the Solicitor General Act, we are pleased to submit the Midwifery Services Review Committee Report.

All of which is respectfully submitted.

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Margaret Mrazek, Chair

Sandra Botting
Sandra Botting

Judy Cochrane
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Peggy-Anne Field
Dr. Peggy-Anne Field

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TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY i

SUMMARY OF RECOMMENDATIONS vi

I. INTRODUCTION 1

1. Background 2
2. Terms of Reference and Membership 4
   A. Terms of Reference 4
   B. Membership 6
3. Philosophy 8
4. Approach 10

II. SCOPE AND STANDARDS OF PRACTICE 11

Recommendations 12
1. Definition of a Midwife 14
2. Principles for the Provision and Approval of Midwifery Services in Various Settings 15
3. Scope of Practice 16
4. Standards of Midwifery Practice 18
   A. Components of Midwifery Practice 18
      1) General 18
      2) Specific 19
         a) Antepartum Care 19
         b) Intrapartum Care 20
         c) Postpartum Care of the Newborn 22
         d) Postpartum Care of the Mother 22
         e) Education and Counselling 23
         f) Sexuality 24
         g) Collaboration with Other Caregivers 24
         h) Professional, Legal and Other Aspects 24
   B. Conditions and Limitations Applicable to Midwifery Practice in All Settings 25
      1) Criterion for Midwives as Primary Caregivers 25
      2) Criteria for Consultation with a Physician 25
      3) Criteria for Medical Consultation and Transfer of Primary Responsibility 25

III. SETTINGS OF PRACTICE 27

Recommendations 28
1. Midwifery Practice Settings 29
2. Specific Settings of Practice 30
   A. Hospitals 30
   B. Health Units 30

C. Birth Centres 30
D. Other Settings 31
3. Home Births 32
A. Criteria for Home Birth 32
B. Criteria for Mandatory Transport from the Home Birth Setting 33
C. Monitoring Midwife Attended Home Births 34

IV. MIDWIFERY EDUCATION 35
Recommendations 36
1. Educational Qualifications for Registration 37
2. Components of Midwifery Education 38
A. Theoretical and Technical Instruction 38
1) General 38
2) Clinical 39
B. Practical and Clinical Experience 39
3. Development of Future Educational Programs 41
4. Assessing Current Alberta Midwives 42

V. LEGISLATION REGULATING MIDWIVES 44
Recommendations 45
1. Legislative Options 46
2. Regulation Under the *Health Disciplines Act* 47

VI. IMPLEMENTATION OF MIDWIFERY 48
Recommendations 49
1. Introduction 51
2. Regulatory Issues 52
3. Collaboration Between Midwives and Other Health Care Providers 53
4. Institutional Facilities and Arrangements Necessary to Support Midwifery Practice in Various Settings 55
5. Monitoring the Effectiveness of Midwifery Care 57

APPENDIXES 58
Appendix "A" - Documents Utilized by the Midwifery Services Review Committee in its Deliberations 59
Appendix "B" - Drugs Prescribed and Administered by the Registered Midwives . . 61
Appendix "C" - Screening and Diagnostic Tests 63
Appendix "D" - Criteria for Medical Consultation and Transfer of Primary Responsibility 64

DEFINITIONS 72

EXECUTIVE SUMMARY

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In February 1991, the Health Disciplines Board submitted its Final Report and Recommendations on its investigation of midwifery to the Government of Alberta. The report recommended that midwifery be designated under the *Health Disciplines Act*. The Board also identified several issues which the Government felt required further study before it could make a decision regarding designation.

On September 17, 1991, the Government established the Midwifery Services Review Committee to examine these issues and to address a number of other matters that were beyond the scope of the Board's investigation. The Committee was to enquire into and provide advice to the Government on:

- the form of legislation or specific statute under which midwifery would most appropriately be regulated;
- the services midwives should be allowed to provide in the course of practising midwifery, and any conditions or limitations that are applicable to the provision of those services;
- standards of practice for midwifery;
- components of midwifery training that provide the knowledge and technical skills necessary for safe and effective midwifery practice;
- educational and experiential qualifications that should be required of midwives in Alberta to ensure practitioners meet defined standards of practice and competency;
- means for assessing the qualifications and educational backgrounds of midwives currently practising in Alberta or other jurisdictions;
- mechanisms and processes for encouraging collaboration between midwives and other health care providers; and
- institutional facilities and arrangements necessary to support midwifery practice in various settings.

The Committee examined how midwifery is practised and regulated in other jurisdictions in order to build upon the knowledge, experience and expertise these jurisdictions have developed. The Committee's recommendations are consistent with the approaches, standards and practice models used in other jurisdictions where these were compatible with Canada's system of health care. The information from other jurisdictions which has been incorporated into the recommendations has been discussed extensively and, where appropriate, revised to ensure the particular circumstances in Alberta are reflected in the report. The Committee was conscious of the need to ensure, as far as possible, that Alberta's direction regarding midwifery practice be consistent with other provinces. As midwifery gradually becomes established throughout Canada, the Committee hopes that there will be sufficient commonality in the standards and scope of practice in Alberta and elsewhere so as to ensure portability of credentials and reciprocity of registration for midwives, in keeping with such opportunities for other health care providers.

The Committee reviewed approaches to the provision of midwifery care in several jurisdictions and identified the following set of principles which it believes should guide regulators, midwives, employers, facilities and the funding bodies for midwifery services and practices in Alberta:

- midwifery service as a health service should be accessible for women in Alberta in keeping with the principles of the *Canada Health Act*;
- midwives should practice as autonomous primary caregivers within their scope of practice. Other health care providers and administrators should respect midwives' autonomy and recognize their ability to provide primary care during pregnancy, labour, childbirth and the postpartum period. Midwives should be able to practice collaboratively with other health care providers in clinical practice settings, including making and accepting referrals, and participating in education, research and quality assurance programs;
- midwives may care for women who have uncomplicated pregnancies and for whom a normal labour and birth are anticipated. Although the focus of midwives should be on low-risk pregnancies and normal childbirth, they may also care for higher risk patients in collaboration with physicians because of the specific benefits of midwifery care for these particular women;
- midwives caring for women during pregnancy should provide care during labour, childbirth and the postpartum period to ensure continuity of care. The scope of practice of midwives encompasses every stage of the childbearing cycle and includes counselling, educating and providing emotional support relating tc women's psychological and social needs, which are essential components of midwifery care;
- midwives may practice in a variety of settings. For example, midwives based in hospitals and other health care facilities should be able to provide care in community settings, and midwives based in the community should be able to provide labour and childbirth care to their clients in hospitals or other health care facilities; and
- evaluation of midwifery care provided in different settings should be undertaken as services are implemented. Results of such evaluations should be widely distributed to influence policy, education and midwifery practice.

The Committee developed a scope of practice statement that it recommends be adopted by the regulatory body governing midwifery in Alberta (see Chapter II, Section 3). In developing standards of practice for midwifery, the Committee described in detail the services registered midwives would be able to provide, and the knowledge and skills required to provide those services safely and effectively (see Chapter II, Section 4).

Further, the Committee recommended that the following conditions and limitations should apply to the practice of midwifery in Alberta, regardless of the particular setting:

- midwives may provide care as primary caregivers for any woman, unless the woman presents with or is found to have any of the contraindications outlined in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D");

- there should be an initial medical consultation for advice, to establish a link with a physician during pregnancy and to confirm that there is no medical condition present which would preclude a midwife from being the primary caregiver;
- circumstances may occur throughout the childbearing cycle where there is a deviation from the normal which requires consultation to confirm the presence of the deviation or the transfer of primary responsibility of a client to a physician. These circumstances have been set out in the "Criteria for Medical Consultation and Transfer of Primary Responsibility", outlined in Appendix "D". These criteria should be adopted by the regulatory body established to govern midwifery.

In order for midwifery to be successfully integrated into Alberta's health care system, formal settings for midwifery practice should include hospitals, health units, birth centres and other settings which provide the personnel, equipment, resources and systems necessary for safe and effective midwifery care. The Committee believes registered midwives will have the necessary competence to practice in any or all of these settings. In keeping with the principles of consumer choice, autonomous regulated practice, and continuity of care, midwives must have legislative authority to practice within the setting that most appropriately meets the needs of their clients in a manner consistent with the standards recommended in this report.

All midwives, irrespective of their employment situation or primary setting of practice, must be eligible for hospital privileges. Direct access to resources in hospitals is integral to midwives being able to function as primary caregivers.

Recognizing that women have the right to choose where they give birth, the Committee believes, provided appropriate standards are established, that midwives should be permitted to attend childbirth in women's homes. However, women who choose to give birth at home must be able to be transported, within 30 minutes, to a hospital capable of dealing with obstetrical emergencies.

Further, midwives who attend home births must be responsible for having at hand well-maintained equipment, supplies and drugs that may be required during labour, delivery or the postpartum period. As well, midwives must have in place a defined back-up system which includes a midwife who can be available to assist at the time of birth, a physician who can be available, if required, at a hospital capable of dealing with the obstetrical emergency, and established links with the emergency service in the community and the Regional Perinatal Service in case an emergency occurs. If any of the conditions identified as criteria for mandatory transport from the home birth setting arise (see Chapter III, Section 3B), the midwife is required to transport the client(s) to a hospital capable of dealing with the obstetrical emergency.

After a review of information from other jurisdictions, the Committee believes that through careful selection of clients and by ensuring that midwives meet the standards for registration set out in this report, consumer demand for more choice in birthing locations, particularly home birth, can be met in a safe and effective manner.

The integration of midwifery into Alberta's health care system presents an opportunity for a properly designed and implemented prospective study to be undertaken to compare the effectiveness of midwifery care and the outcomes of midwife attended births in both home and hospital settings.

With respect to educational qualifications, the Committee recommends that, to be eligible for registration in Alberta, midwives should have successfully completed a baccalaureate degree program in midwifery that provides the knowledge and skills identified in the "Components of Midwifery Practice" set out in Chapter II, Section 4A, or an equivalent combination of education and experience as determined by the regulatory body established to govern midwifery.

A Midwifery Assessment and Upgrading Program should be developed to prepare current Alberta midwives for registration. In order to successfully complete the program, and therefore become eligible for initial registration to practice, all midwives should have the knowledge and skills the Committee has identified as necessary for safe and effective midwifery care. This program should be available to current Alberta midwives who have received formal education in midwifery, or who have extensive experience as midwives. The upgrading component of the program would be a one-time, time-limited opportunity tailored to the needs of each individual candidate.

The implementation of midwifery will have important implications for the health care system in Alberta. Changes will be required to ensure that the institutional facilities and arrangements necessary to support midwifery practice in various settings will be in place. The Committee believes that Alberta Health must play the lead role in facilitating the implementation of midwifery services by establishing appropriate consultation processes to address such issues as the funding of midwifery services, modes of remuneration for midwives, creative and innovative approaches to incorporating midwifery into various settings, and any other issues that may arise as midwifery services are established.

The Committee believes the recommendations outlined in this report have struck an appropriate and responsible balance between the needs and preferences of consumers and public protection and accountability for practice. It recommends that midwifery be regulated under the *Health Disciplines Act*, and that the Government proceed as quickly as possible to recognize midwifery and develop a framework for registering midwives and regulating midwifery practices.

SUMMARY OF RECOMMENDATIONS

SUMMARY OF RECOMMENDATIONS

SCOPE AND STANDARDS OF PRACTICE

The Committee recommends that:

1) Midwifery service as a health service be accessible for women in Alberta in keeping with the principles in the *Canada Health Act*.

2) Midwives provide primary care for women with uncomplicated pregnancies who wish to engage their services.

3) Midwives be granted the right to practice as autonomous health care providers within the scope of practice set out in the report.

4) Midwives care for women throughout the childbearing cycle to ensure continuity of care.

5) Midwives be permitted to practice in a variety of settings.

6) Midwives be fully integrated into the health care delivery system.

7) Evaluation of midwifery care be undertaken as services are implemented.

8) Any approved and provincially funded midwifery service meet the principles set out in Chapter II, Section 2, "Principles for the Provision and Approval of Midwifery Services in Various Settings".

9) The Scope of Practice statement outlined in the report be adopted by the regulatory body established to govern midwifery in Alberta.

10) Midwives may provide care as primary caregivers for any woman, unless the woman presents with or is found to have any of the contraindications outlined in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D").

11) There be an initial medical consultation to establish a link with a physician during pregnancy, and to confirm that there is no medical condition present which would preclude a midwife from being the primary caregiver. Further consultations may be required when indicated by the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D").

12) The Regulation developed to regulate midwifery practice provide that midwives be responsible for advising their clients to consult initially with a physician.

13) The "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D") be adopted by the regulatory body governing midwifery to identify when

midwives shall either seek consultation with a physician or transfer responsibility for primary care to a physician.

SETTINGS OF PRACTICE

The Committee recommends that:

1) Formal settings for midwifery practice include hospitals, health units, birth centres and other settings which have available the personnel, equipment, resources and systems necessary for safe and effective midwifery care.

2) All midwives, irrespective of their employment situation or primary setting of practice, must be eligible for hospital privileges.

3) The feasibility of establishing publicly funded birth centres in Alberta be considered.

4) Any woman who may receive care from a midwife as a primary caregiver as determined by the "Criterion for Midwives as Primary Caregivers" (see Chapter II, 4B 1)) have the opportunity to give birth at home under the care of a midwife, provided the woman can be transported within 30 minutes to a hospital capable of dealing with obstetrical emergencies.

5) Midwives who attend home births must have in place a defined back-up system which includes a midwife who can be available to assist at the time of birth, a physician who can be available, if required, at a hospital capable of dealing with the obstetrical emergency, and established links with the emergency service in the community and the Regional Perinatal Service if an emergency occurs.

6) If any of the conditions identified in the "Criteria for Mandatory Transport from the Home Birth Setting" (see Chapter III, Section 3B) arise, the midwife be required to transport the client(s) to a hospital capable of dealing with the obstetrical emergency.

7) A properly designed and implemented prospective study comparing the effectiveness of midwifery care and outcomes of midwife attended births in home and hospital settings be undertaken simultaneously with the introduction of midwifery.

MIDWIFERY EDUCATION

The Committee recommends that:

1) To be eligible for registration in Alberta, midwives should have successfully completed a baccalaureate degree program in midwifery that provides the knowledge and skills identified in the "Components of Midwifery Practice" set out in Chapter II, Section 4A, or an equivalent combination of education and experience as determined by the regulatory body established to govern midwifery.

2) The regulatory body established to govern midwifery be responsible for determining which educational programs adequately prepare midwives for practice in the Province of Alberta.

3) The regulatory body established to govern midwifery utilize the "Components of Midwifery Education" set out in Chapter IV, Section 2A, in making its determination as to which education programs adequately prepare midwives for practice in the Province of Alberta.

4) To provide for the registration of current Alberta midwives, a Midwifery Assessment and Upgrading Program be developed in keeping with the principles outlined in the report.

LEGISLATION REGULATING MIDWIFERY

The Committee recommends that:

1) Midwifery be regulated under the *Health Disciplines Act*.

IMPLEMENTATION OF MIDWIFERY

The Committee recommends that:

1) Government proceed as quickly as possible to recognize midwifery and develop a framework for registering midwives and regulating midwifery practice through:

   a) amending the *Health Disciplines Act* during the next session of the Legislative Assembly, to recognize midwifery as a designated discipline under the Act;

   b) establishing a Regulation Development Committee to draft a Midwifery Regulation;

   c) having the Health Disciplines Board coordinate a review of the draft Midwifery Regulation; and

   d) proclaiming the Midwifery Regulation and constituting the Regulation Development Committee as the regulating body responsible for implementing the Regulation and governance of midwifery.

2) Midwifery services must be publicly funded.

3) Methods of remuneration, mechanisms for initial and ongoing assessments of formal midwifery care programs and criteria for future Government funding of the programs should be developed within the concepts and recommendations set out in the report.

4) Midwifery services be integrated into the province's health care system in a manner that does not result in a duplication of services or unnecessary additional costs.

5) Alberta Health play a lead role in facilitating the implementation of midwifery services by establishing appropriate consultation processes to address the implementation issues identified in the report and other issues that may arise as midwifery services are established.

6) Processes for monitoring the effectiveness of midwifery care be identified and implemented simultaneously with the introduction of regulated midwifery services in Alberta.

7) The prospective study referred to in Chapter III, Section 3C, be supported by the Government and affected stakeholders have input into its development and access to the results.

I.

INTRODUCTION

1. BACKGROUND

Midwifery is an established discipline in 202 of the 210 member nations of the World Health Organization. However, until recently, Canada was one of the few western nations that did not recognize and regulate midwifery. In November 1991, Ontario became the first province in Canada to pass legislation recognizing midwifery. Quebec has not legally recognized midwifery as a profession but has made provision for funding of midwifery demonstration projects. Other provinces, such as British Columbia, Manitoba, and Nova Scotia, are considering formal recognition of midwives. This move toward recognition of midwifery in Canada reflects the increasing consumer demand for choice in health care services including maternity care, as well as the lobby efforts of midwives in these provinces. In Alberta, there has also been a strong lobby from consumers and midwives to legally recognize midwifery.

Attempts to have midwifery recognized in Alberta began in 1982 when the Alberta Council and Register of Domiciliary Midwives Association (ACRDMA) applied to the Health Disciplines Board for designation of domiciliary midwives under the *Health Disciplines Act*. The Board investigated the matter and recommended to the Government that domiciliary midwifery not be designated. This decision was based on the finding that the ACRDMA did not represent all those in Alberta who professed to be midwives. Indeed, another midwifery organization, the Western Nurse Midwives Association, opposed designation.

The Health Discipline Board's recommendation to Government was that:

> **"... the occupation of domiciliary midwifery should not be ... designated ... because domiciliary midwifery is a ... subset of a larger occupation of midwifery (in all settings). The Board does not believe that it is in the public interest to partition this occupation into several parts."**

However, the Board added that:

> **"... this recommendation should not be seen to bias an investigation of the total occupation of midwifery if (such) an application (for designation) is ever received."**

In 1986, the ACRDMA and the Western Nurse-Midwives Association merged to form the Alberta Association of Midwives (AAM). Subsequently, in August 1989, the AAM applied to the Board for designation of the total discipline of midwifery.

The Board responded by carrying out another investigation of the discipline. It invited 107 organizations to submit written briefs on midwifery, and 62 of them responded. The Board also invited public input, and some 240 citizens submitted letters outlining their views on midwifery. The Board concluded the investigation by hearing presentations from 14 organizations and four

individuals who had some particular interest in or knowledge about this issue.[1] The Board found that individual citizens were overwhelmingly in favour of midwifery in general and home birth in particular. There was also strong support on the part of organizations consulted that some form of midwifery should be recognized and regulated.

Several of the organizations, however, identified issues that they felt had to be addressed if they were to accept legalized midwifery. Three of these issues became focal points of the investigation. The first issue related to the educational preparation of midwives. A number of groups argued that midwives should have prior training as registered nurses. The second issue related to the first; that midwifery should be regulated under the *Nursing Profession Act* rather than the *Health Disciplines Act*. The third issue was whether or not midwives should be allowed to attend planned home births.

The Health Disciplines Board concluded its review by making the following recommendations to Government:

> **"the degree of risk associated with the practice of midwifery is such that the discipline should be designated under the *Health Disciplines Act*;**
>
> **registration as a midwife under the *Health Disciplines Act* should not be restricted to individuals who have a registered nursing qualification;**
>
> **a Midwifery Implementation Advisory Committee, which includes representatives from the Alberta Association of Midwives, the College of Physicians and Surgeons, the Alberta Association of Registered Nurses, the Alberta (Healthcare) Association, and the public (should) be established to advise the Board on implementation issues;**
>
> **home births (should) be included in the scope of practice of midwifery; (and)**
>
> **the multi-disciplinary Midwifery Implementation Advisory Committee (should) advise the Board on conditions and restrictions to be required for midwives' attendance at planned home births, taking into account risk, experience, and access to medical support services."**

The Board's report and the above recommendations were presented to the Government in February 1991.

The Midwifery Services Review Committee was established by Government on September 17, 1991, to examine the issues identified by the Board as requiring further study and to address a number of other matters that were beyond the scope of the Board's investigation.

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[1]For further details regarding these submissions (and a complete account of the Board's investigation), see Alberta Health Disciplines Board, Investigation of Midwifery: Final Report and Recommendations, Edmonton: Professions and Occupations Bureau, Government of Alberta, February 1991.

2. TERMS OF REFERENCE AND MEMBERSHIP

A. TERMS OF REFERENCE

The Committee was established to enquire into and provide advice to the Government on:

1) **the form of legislation or specific statute under which midwifery would most appropriately be regulated;**

For legislative regulation of midwives, see pages 44-47.

2) **the services midwives should be allowed to provide in the course of practising midwifery, and any conditions or limitations that are applicable to the provision of those services;**

For Scope of Practice of Midwives, see pages 16 and 17; also see Components of Midwifery Practice, pages 18-24. For conditions and limitations on midwifery practice, see pages 25 and 26 and Appendix "D". Also see Criteria for Mandatory Transport from Home Birth Setting, pages 33 and 34.

3) **standards of practice for midwifery including:**

- **criteria for determining a woman's suitability to receive primary care during pregnancy and childbirth from a midwife;**

  For determining a woman's suitability to receive primary care from a midwife, see Criterion for Midwives as Primary Caregivers, page 25.

- **criteria and protocols for midwives regarding consultations with, or referral of cases to, other health care providers (e.g. physicians); and**

  For Criteria for Consultation with a Physician, see page 25 and Appendix "D".

- **criteria and protocols for the provision of midwifery care in various settings;**

  For Principles Applicable to Midwifery Services in Various Settings, see page 15. Also see Settings of Practice, Chapter III, pages 27-34.

4) **components of midwifery training that provide the knowledge and technical skills necessary for safe and effective midwifery practice;**

For Components of Midwifery Education, see pages 38-40.

5) **educational and experiential qualifications that should be required of midwives in Alberta to ensure practitioners meet defined standards of practice and competency;**

For Educational Qualifications for Registration, see page 37. Also see Development of Future Educational Programs, page 41.

6) **means for assessing the qualifications and educational backgrounds of midwives currently practising in Alberta or other jurisdictions;**

For Assessing Current Alberta Midwives, see pages 42 and 43.

7) **mechanisms and processes for encouraging collaboration between midwives and other health care providers; and**

See pages 53 and 54 for a review of mechanisms and processes for encouraging collaboration between various members of the health care team and midwives.

8) **institutional facilities and arrangements necessary to support midwifery practice in various settings.**

See pages 55 and 56 for information relating to arrangements necessary to support midwifery practice.

B. MEMBERSHIP

The membership of the Committee was as follows:

Margaret Mrazek
Chair, Public Member
Lawyer, Registered Nurse, and former Health Care Executive

Sandra Botting
Representative of the Alberta Association of Midwives
President, Alberta Association of Midwives

Judy Cochrane
Public Member
Childbirth educator, nurse and founder of
Edmonton Vaginal Birth After Caesarean Association

Peggy-Anne Field
Representative of the Alberta Association of Midwives
Professor, Maternal Newborn Nursing, Faculty of Nursing, University of Alberta,
Registered Nurse and Midwife

Karen Gainer
Representative of the Health Unit Association of Alberta
Lawyer, and Chair, Calgary Board of Health

Betty Gourlay
Representative of the Alberta Association of Registered Nurses
Registered Nurse in self-employed practice

Holly Hutton LaMonaca
Public Member
President, Calgary Association of Parents & Professionals for Safe
Alternatives in Childbirth

Nancy O'Brien
Representative of the Alberta Healthcare Association
Director, Patient Care Services, Alberta Healthcare Association

Douglas K. Still
Representative of the College of Physicians and Surgeons of Alberta
Obstetrician, Associate Professor, Obstetrics and Gynaecology, University of Alberta,
Director of Maternal Fetal Medicine, University of Alberta Hospital

Dan Charlton (non-voting member)
Representative of the Alberta Professions and Occupations Bureau
Registrar, Health Disciplines

Brenda Johnson (non-voting member)
Representative of Alberta Health
Assistant Director, Planning

Bill Novasky (non-voting member)
Representative of Alberta Advanced Education
Director, Program Coordination Branch

Allan Rachinski Administrative Assistant to Committee
Alberta Professions and Occupations Bureau

3. PHILOSOPHY

The Committee recognizes that Albertans wish to have a broader range of health care services including maternity service available to them. In this regard, the Committee found the following principles enunciated in The Rainbow Report, published by the Premier's Commission on Future Health Care for Albertans,[2] served as a useful framework for discussions and deliberations in the Committee:

> "We believe in people being the focus of the health system; in free and voluntary choice (and) personal responsibility ...; in the inevitability and desirability of change ...; in health decisions which are most effective and least intrusive; and in making the opportunity available to all Albertans to maximize their own health."[3]

The Committee considered and ensured its recommendations were consistent with the principles in the *Canada Health Act*[4] relating to the provision of health service in Canada: universality, comprehensiveness, accessibility, portability, and public administration.

The recently released report, "Partners in Health - The Government of Alberta's Response to the Premier's Commission on Future Health Care for Albertans",[5] reinforced Government's continuing support for the principles of choice and responsibility for one's own health. Further, this report reaffirms Government's support for the above noted principles in the *Canada Health Act* and provides policy direction for future health care reform.

The Committee also believes that choice and individual responsibility for health resource utilization must be balanced against other factors, particularly the need for public protection. As the Terms of Reference clearly indicate, the Committee's primary responsibility was to advise the Government regarding standards which would ensure provision of safe and effective midwifery care.

In this regard, the Committee also found the following statement in the Government of Alberta's report, Principles and Policies Governing Professional Legislation in Alberta[6], a useful guide in its efforts to strike an appropriate balance between choice and public protection:

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[2]Government of Alberta, "Premier's Commission on Future Health Care For Albertans", The Rainbow Report: Our Vision for Health, Vol. I, Edmonton, 1989.

[3]Ibid, page 17.

[4]Statutes of Canada, 1989, Chapter C-6.

[5]Government of Alberta, Partners in Health: The Government of Alberta's Response to the Premier's Commission on Future Health Care for Albertans, Edmonton, 1991.

[6]Government of Alberta, Principles and Policies Governing Professional Legislation in Alberta, Edmonton, June 1990.

"In order to promote the interests of the public, professional legislation shall establish standards, procedures and controls which, to the fullest extent possible:

i) protect service users and the public ...
ii) promote quality, efficiency and cost-effectiveness in the provision of professional services
iii) balance the rights and responsibilities of professionals, service users and the public
iv) enable service users to exercise informed judgment and freedom of choice with respect to professional services."

In the chapters that follow, the Committee has made recommendations which it believes are in compliance with the aforementioned principles.

4. APPROACH

The Committee used as a starting point for its deliberations information about how midwifery is practised and regulated in other jurisdictions. This approach permitted the Committee to utiiize previously developed knowledge, experience and expertise. The Committee's recommendations are consistent with the approaches, standards and practice models used in other jurisdictions where these were considered to be compatible with Canada's system of health care. The information from these other jurisdictions was discussed extensively and, where appropriate, revised to ensure that the Committee's recommendations reflect the particular circumstances found in Alberta.

Throughout the Committee's deliberations, information collected by the Health Disciplines Board during its investigation of midwifery, the Ontario Task Force on the Implementation of Midwifery, and the Interim Regulatory Council on Midwifery as well as documentation from Arizona, the Netherlands and the European Community was considered.[7] As well, the Committee met with Dr. Karyn Kaufman to review the findings from the investigation of midwifery which took place in Ontario, and the legislative framework developed for that province.[8]

The Committee also followed with interest developments in other provinces, such as Manitoba, British Columbia, Quebec and Nova Scotia, where recognition of midwifery is under active consideration. Throughout its deliberations, the Committee was conscious of the need to ensure, as far as possible, that Alberta's direction be similar to those of other provinces. As midwifery gradually becomes established throughout Canada, the Committee hopes that there will be sufficient commonality in the standards and scope of practice in Alberta and elsewhere so as to ensure portability of credentials and reciprocity of registration for midwives, in keeping with such opportunities for other health care providers.

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[7]The Committee used as a basis for its deliberations and recommendations the documents outlined in Appendix "A".

[8]Dr. Karyn Kaufman is the former implementation coordinator for Midwifery in Ontario's Ministry of Health and one of Canada's foremost authorities on midwifery.

II.

SCOPE AND STANDARDS OF PRACTICE

II. SCOPE AND STANDARDS OF PRACTICE

RECOMMENDATIONS:

PRINCIPLES FOR THE PROVISION AND APPROVAL OF MIDWIFERY SERVICES IN VARIOUS SETTINGS

The Committee recommends that:

1) Midwifery service as a health service be accessible for women in Alberta in keeping with the principles in the *Canada Health Act*.

2) Midwives provide primary care for women with uncomplicated pregnancies who wish to engage their services.

3) Midwives be granted the right to practice as autonomous health care providers within the scope of practice set out in the report.

4) Midwives care for women throughout the childbearing cycle to ensure continuity of care.

5) Midwives be permitted to practice in a variety of settings.

6) Midwives be fully integrated into the health care delivery system.

7) Evaluation of midwifery care be undertaken as services are implemented.

8) Any approved and provincially funded midwifery service meet the principles set out in Chapter II, Section 2, "Principles for the Provision and Approval of Midwifery Services in Various Settings".

SCOPE OF PRACTICE

The Committee recommends that:

1) The Scope of Practice statement outlined in the report be adopted by the regulatory body established to govern midwifery in Alberta.

STANDARDS OF PRACTICE

The Committee recommends that:

1) Midwives may provide care as primary caregivers for any woman, unless the woman presents with or is found to have any of the contraindications outlined in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D").

2) There be an initial medical consultation to establish a link with a physician during pregnancy, and to confirm that there is no medical condition present which would preclude a midwife from being the primary caregiver. Further consultations may be required when indicated by the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D").

3) The Regulation developed to regulate midwifery practice provide that midwives be responsible for advising their clients to consult initially with a physician.

4) The "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D") be adopted by the regulatory body governing midwifery to identify when midwives shall either seek consultation with a physician or transfer responsibility for primary care to a physician.

1. DEFINITION OF A MIDWIFE

In determining the scope of services midwives should be allowed to provide, the Committee initially endorsed, with minor modifications, the following definition of a midwife written by the International Confederation of Midwives:

> [The midwife] must be able to give the necessary supervision, care and advice to women during **normal** pregnancy, labour and the postpartum period, to conduct deliveries on her/**his** own responsibility and to care for the newborn and the mother. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance **when abnormalities are detected** and the execution of emergency measures in the absence of medical help. The midwife has an important task in health counselling and education, not only for the clients but also within the family and community. The work should involve antenatal education and preparation for parenthood, and extends to certain areas of gynaecology, family planning and child care.
>
> **The midwife** may practise in hospitals, clinics, health units, **community health centres,** domiciliary conditions or in any other service.
>
> (The modifications made by the Committee have been set out in **bold** print.)

The modifications were made by the Committee to further define and clarify the terms.

The unmodified definition has been accepted by such organizations as the World Health Organization and the International Federation of Obstetricians and Gynecologists.

Utilizing the above definition as the basis for defining the services midwives can provide, the Committee went on to review information relating to the scope of midwifery practice from the Netherlands, the European Community, Arizona and Ontario. This review formed the basis for the scope of practice statement outlined in Section 3 of this Chapter and for the more detailed "Components of Midwifery Practice" in Section 4.

In Section 2, the Committee sets out principles which it believes should guide the establishment of all midwifery services in the Province of Alberta. Adherence to these principles would ensure that the scope of practice the Committee recommends for midwives can be practiced by these health care providers.

2. PRINCIPLES FOR THE PROVISION AND APPROVAL OF MIDWIFERY SERVICES IN VARIOUS SETTINGS

After reviewing approaches to the provision of midwifery care in several jurisdictions, the Committee identified a set of principles which it believes should guide regulators, midwives, employers, facilities and the funding bodies of midwifery services and practices in Alberta. These principles are applicable regardless of the particular setting in which midwifery is practised. The establishment of midwifery services based on these principles should ensure that midwives can provide continuity of care throughout the childbearing cycle as identified in the "Components of Midwifery Practice" set out in Section 4 of this Chapter. The Committee therefore recommends that any approved and provincially funded midwifery service should meet the following principles:

1) Midwifery service as a health service should be accessible for women in Alberta in keeping with the principles of the *Canada Health Act*.

2) Midwives should practice as autonomous primary caregivers within their scope of practice. Other health care providers and administrators should respect midwives' autonomy and recognize their ability to provide primary care during pregnancy, labour, childbirth, and the postpartum period. Midwives should be able to practice collaboratively with other health care providers in clinical practice settings including making and accepting referrals, and participating in education, research, and quality assurance programs.

3) Midwives may care for women who have uncomplicated pregnancies and for whom a normal labour and birth are anticipated. Although the focus of midwives should be on low-risk pregnancies and normal childbirth, they may also care for higher risk patients in collaboration with physicians because of the specific benefits of midwifery care for these particular women.

4) Midwives caring for women during pregnancy should provide care during labour, childbirth and the postpartum period to ensure continuity of care. The scope of practice of midwives encompasses every stage of the childbearing cycle and includes counselling, educating and providing emotional support relating to women's psychological and social needs, which are essential components of midwifery care.

5) Midwives may practice in a variety of settings. For example, midwives based in hospitals and other health care facilities should be able to provide care in community settings, and midwives based in the community should be able to provide labour and childbirth care to their clients in hospitals or other health care facilities.

6) Evaluation of midwifery care provided in different settings should be undertaken as services are implemented. Results of such evaluations should be widely distributed to influence policy, education and midwifery practice.

3. SCOPE OF PRACTICE

The following scope of practice statement defines the services a midwife should be legally entitled to provide in order to facilitate the effective regulation and implementation of midwifery in Alberta. This statement should provide midwifery practitioners, regulators, employers, other health care providers and the public with the parameters of midwifery practice. The Committee recommends that this statement be adopted by the regulatory body governing midwifery in Alberta.

A registered midwife functioning as a primary caregiver may provide the following health services:

1) carry out examinations necessary to confirm and monitor normal pregnancies;

2) advise on and secure the examinations necessary for the earliest possible diagnosis of pregnancies at risk;

3) provide counselling and education in preparation for childbirth;

4) care for the woman and monitor the condition of the foetus during labour;

5) conduct spontaneous vaginal deliveries;

6) identify the warning signs of abnormality in the woman or foetus that necessitate referral to a physician;

7) take emergency measures when necessary;

8) examine and care for the newborn; and

9) care for the mother in the postpartum period and advise her on newborn and infant care and family planning.

In the course of practising midwifery, a registered midwife may:

1) perform episiotomies and amniotomies and repair episiotomies and lacerations not involving the anus, anal sphincter, rectum, urethra and periurethral area;

2) independently prescribe and administer the drugs listed in Appendix "B";

3) on the order of a physician, independently administer any drugs by the route and in the dosage specified by the physician;

4) order the screening and diagnostic tests listed in Appendix "C";

5) screen potential clients during the initial interview and either accept or decline to care for a client or make a referral at the midwife's discretion; and

6) transfer primary care of a client to a physician if conditions arise requiring management outside of the scope of practice for midwives, and continue to provide collaborative care to the extent determined jointly by the client, physician and midwife.

4. STANDARDS OF MIDWIFERY PRACTICE

In developing standards of practice for midwifery, the Committee felt it was important to begin by describing (in more detail than is outlined in Section 3 - Scope of Practice) the services registered midwives would be able to provide, and the knowledge and skills required to provide those services safely and effectively. The following components of midwifery practice provide a detailed description of the required knowledge and skills. This statement should be used as a guideline by the regulatory body established to govern midwifery. It also forms the basis for the Committee's recommendations regarding midwifery education in Chapter IV.

A. Components of Midwifery Practice

1) General

The following components of midwifery practice define the general knowledge and skills registered midwives must have and apply throughout the childbearing cycle:

a) provide the necessary care and advice to women during pregnancy, labour and the postpartum period;
b) provide continuity of care throughout the childbearing cycle;
c) provide care focused on the woman and her family;
d) promote normal birth and use technology appropriately;
e) provide care in a variety of settings, including hospitals, birthing centres and homes;
f) order and perform screening and diagnostic tests as specified by Regulation;
g) identify risk factors, including genetic risks, before pregnancy, during pregnancy, labour and the postpartum period, and take appropriate action;
h) provide education, health promotion and counselling relating to childbearing and family planning for the woman, her family and the community;
i) assist the woman and her family in planning for an appropriate place of birth;
j) identify abnormal conditions, recommend appropriate treatment and make referrals, as required;
k) facilitate informed decision-making;
l) conduct deliveries on their own responsibility, and care for the newborn;
m) prescribe and administer drugs as specified by Regulation;
n) establish and maintain comprehensive, relevant and confidential records;
o) use emergency measures when necessary;
p) apply research findings to midwifery practice; and
q) practice in an ethical manner.

2) Specific

From the general components of midwifery practice, the following sections define the specific knowledge and skills midwives must have and apply to particular aspects of midwifery care:

a) Antepartum Care

i) Registered midwives should have knowledge of:

(1) the importance and functions of pre-pregnancy counselling;
(2) the importance and functions of antepartum care;
(3) general anatomy and physiology;
(4) anatomy and physiology of the reproductive system from menarche to menopause;
(5) physical, emotional and social changes associated with pregnancy;
(6) physical, emotional and social factors likely to influence pregnancy outcome;
(7) clinical implications of genetics, embryology and fetal development for pregnancy outcome;
(8) nutritional requirements for pregnancy;
(9) the physiology and management of common discomforts during pregnancy;
(10) methods for diagnosing pregnancy, establishing due date, assessing current gestational age and assessing the progress of pregnancy;
(11) screening and diagnostic tests used during pregnancy;
(12) drugs which may be used during pregnancy;
(13) environmental, genetic, biological and pharmacologic hazards to pregnant women;
(14) causes, recognition and treatment of abnormalities which may occur during pregnancy;
(15) implications of sexually transmitted diseases and vaginal infections prior to and during pregnancy;
(16) principles and procedure of external cephalic version; and
(17) genetic screening tests.

ii) Registered midwives should have the ability to:

(1) obtain a family, medical and social history;
(2) perform a complete physical assessment;
(3) obtain maternal blood pressure, pulse, respirations, temperature and weight measurements, undertake urinalysis and recognize abnormal findings;
(4) assess uterine size, fetal position and presentation, and estimate fetal size and gestational age;

(5) perform a pelvic and speculum examination and assess the soft and bony structures of the pelvis;
(6) confirm pregnancy;
(7) obtain cervical and vaginal specimens;
(8) perform venipuncture and finger puncture;
(9) assess the pregnant woman's general health and well-being;
(10) assess nutritional status and provide appropriate counselling;
(11) auscultate fetal heart;
(12) evaluate fetal movement;
(13) assess presence and degree of edema;
(14) check for costal vertebral angle tenderness;
(15) check for clonus and deep tendon reflexes;
(16) obtain the necessary specimens to evaluate the presence of sexually transmitted diseases, vaginal infections and cytological changes;
(17) interpret results of routine screening and diagnostic tests; and
(18) counsel women at risk regarding fetal abnormalities.

b) Intrapartum Care

i) Registered midwives should have knowledge of:

(1) the normal process of labour including the mechanisms of labour and birth;
(2) assessment of maternal and fetal well-being;
(3) assessment of the onset and progress of labour and birth;
(4) comfort and support measures during labour and birth;
(5) use of physiologic methods to facilitate labour;
(6) anatomy of the fetal skull and its landmarks;
(7) fetal heart rate patterns;
(8) aseptic technique and its application during labour;
(9) significance of ruptured membranes and methods for reducing risks of infection;
(10) abnormalities of labour;
(11) prevention, assessment and management of dehydration and ketonuria during labour;
(12) techniques to protect the perineum, avoid unnecessary episiotomy and minimize lacerations;
(13) indications and procedure for episiotomy;
(14) indications and procedure for repair of lacerations or episiotomy;
(15) the action and appropriate administration of anti-haemorrhagic agents;
(16) drugs which may be used during the intrapartum period;
(17) obstetrical interventions used to assist in labour;
(18) obstetrical interventions used in emergency care; and
(19) neonatal resuscitation, including successful completion of a neonatal advanced life support program.

ii) Registered midwives should have the ability to:

(1) provide appropriate emotional and physical support to the labouring woman and her support people;
(2) conduct a spontaneous labour and delivery;
(3) assess the onset and progress of labour;
(4) assess frequency, duration and intensity of uterine contractions;
(5) identify and determine station of the fetal presenting part, and assess position, presentation, attitude, and the presence of moulding;
(6) assess fetal heart tones with a fetoscope, doppler and electronic fetal monitor;
(7) recognize abnormal labour patterns, identify probable causes and take appropriate action;
(8) assess effacement and dilation of the cervix;
(9) determine status of the fetal membranes and perform amniotomy if appropriate;
(10) recognize a full bladder and catheterize if appropriate;
(11) protect the perineum, avoid unnecessary episiotomy and minimize lacerations;
(12) perform and repair episiotomy when indicated in accordance with conditions and restrictions specified by Regulation;
(13) inspect the perineal and vulval areas for lacerations, haematomas, and abrasions and take appropriate action in accordance with conditions and restrictions specified by Regulation;
(14) recognize signs of separation of the placenta, conduct the delivery of and inspect the placenta;
(15) collect cord blood;
(16) recognize and manage postpartum haemorrhage in accordance with conditions and restrictions specified by Regulation;
(17) recognize the signs of maternal shock and initiate treatment;
(18) perform immediate newborn assessment and care;
(19) perform neonatal resuscitation including intubation;
(20) assess the need for effective relief of pain and intervene using non-pharmacological and pharmacological measures as required in accordance with conditions and restrictions specified by Regulation;
(21) perform, when appropriate, injections, insert an intravenous catheter and administer intravenous fluids in accordance with conditions and restrictions specified by Regulation; and
(22) administer inhalants as specified by Regulation.

c) Postpartum Care of the Newborn

i) Registered midwives should have knowledge of:

(1) anatomy and physiology of the newborn;
(2) newborn assessment and gestational age assessment;
(3) signs and symptoms of abnormal conditions in the newborn;
(4) newborn screening and diagnostic testing;
(5) prophylactic medications commonly used for the newborn;
(6) nutritional needs of the newborn, properties of breast milk and infant formula, and methods of infant feeding; and
(7) when to consult with neonatologist or paediatrician.

ii) Registered midwives should have the ability to:

(1) provide initial newborn care and assessment including assessment of respiratory and cardiac status and maintaining temperature;
(2) administer eye prophylaxis and vitamin K;
(3) perform a complete newborn assessment;
(4) assess newborn jaundice and initiate appropriate management;
(5) perform a heel puncture to obtain samples for blood glucose, phenylketonuria (PKU) and other screening tests;
(6) assess the well-being of the newborn in the first six weeks of life and take appropriate action if necessary; and
(7) educate parents regarding newborn behaviour and care.

d) Postpartum Care of the Mother

i) Registered midwives should have knowledge of:

(1) anatomy and physiology of the postpartum period including lactation;
(2) postpartum assessment of the woman;
(3) emotional and psychological aspects of the postpartum period, including breastfeeding and early parenting;
(4) postpartum discomforts and appropriate management;
(5) nutritional requirements for women during the postpartum period;
(6) principles of breastfeeding and management of common breastfeeding problems;
(7) stimulation and suppression of lactation;
(8) assessment and management of postpartum complications;
(9) self-help strategies, including exercise, that will aid the mother in postpartum recovery; and
(10) methods of birth control, family planning and their risks and benefits, including the implications of sexually transmitted diseases.

ii) Registered midwives should have the ability to:

(1) assess the health and monitor the progress of the woman in the postpartum period;
(2) counsel the mother on the benefits of breastfeeding;
(3) assist the mother to establish the chosen method of infant feeding;
(4) educate clients regarding self-care, normal postpartum progress, and signs and symptoms of common postpartum complications;
(5) facilitate the introduction of the new member into the family;
(6) conduct six week postpartum assessment;
(7) perform a bimanual and speculum examination to assess uterine size, shape, consistency and mobility, and cervical and vaginal health;
(8) counsel clients in decision-making regarding contraceptive methods;
(9) instruct clients in the use of contraception; and
(10) fit diaphragms and cervical caps.

e) Education and Counselling

i) Registered midwives should have knowledge of:

(1) principles and the processes of informed decision-making;
(2) principles of adult education, communication and counselling;
(3) theoretical approaches to prenatal and parent education;
(4) issues related to grief and loss in childbearing;
(5) available community resources; and
(6) cultural influences on the childbearing cycle.

ii) Registered midwives should have the ability to:

(1) provide information about care alternatives, including options, risks and benefits, to effect informed decision-making;
(2) identify and respond to clients' educational needs;
(3) communicate effectively with clients and their support people;
(4) assist the woman and her family in planning and preparing for the birth experience and early parenting;
(5) assess the emotional status of the woman;
(6) assess the effectiveness of their own counselling skills;
(7) counsel and support the woman and her family in responding to grief and loss in childbearing;
(8) provide prenatal and parent education; and
(9) respond sensitively to cultural differences in providing care to clients.

f) Sexuality

i) Registered midwives should have knowledge of:

(1) sexuality during the childbearing cycle;
(2) physiological and psychosocial components and common issues of human sexuality; and
(3) factors involved in decision-making about unplanned or unwanted pregnancies and resources for counselling and referral.

ii) Registered midwives should have the ability to:

(1) counsel clients on issues of human sexuality and make referrals where appropriate.

g) Collaboration with Other Caregivers

i) Registered midwives should have knowledge of:

(1) the roles and responsibilities of other health care providers and their standards of care; and
(2) medical terminology relevant to the childbearing cycle.

ii) Registered midwives should have the ability to:

(1) communicate effectively with other caregivers facilitating referral, consultation and collaboration when appropriate.

h) Professional, Legal and Other Aspects

i) Registered midwives should have knowledge of:

(1) the history and philosophy of midwifery in Canada;
(2) the Standards of Practice for midwifery;
(3) a code of ethics (standards of conduct) for the practice of midwifery;
(4) legislation and institutional practices pertaining to midwifery;
(5) legal responsibilities and obligations to clients; and
(6) the health care system in Alberta as it pertains to the practice of midwifery.

B. Conditions and Limitations Applicable to Midwifery Practice in All Settings

This section outlines the Committee's recommendations regarding conditions and limitations that it believes should apply to the practice of midwifery in Alberta, regardless of the particular setting. Chapter III focuses on the particular settings for midwifery practice, and outlines additional conditions and limitations, where appropriate.

1) Criterion for Midwives as Primary Caregivers

The Committee believes midwives should be able to be primary caregivers for any woman with a low risk or normal pregnancy. To define low risk pregnancy, the Committee chose to use the principle of exception. Therefore, the Committee recommends that the following criterion be adopted for determining when midwives may be primary caregivers:

> Midwives may provide care as primary caregivers for any woman, unless the woman presents with or is found to have any of the contraindications outlined in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" in Appendix "D".

This criterion provides a comprehensive guide for midwives throughout the childbearing cycle.

2) Criteria for Consultation with a Physician

The Committee recommends that there should be an initial medical consultation to establish a link with a physician during pregnancy, and to confirm that there is no medical condition present which would preclude a midwife from being the primary caregiver. This medical consultation should occur as early in the pregnancy as possible. The Committee believes the midwife should be responsible for advising the client of this medical consultation and for facilitating such referral. Therefore, the Committee recommends that the regulation developed to regulate midwifery practice provide that midwives be responsible for advising their clients to consult with a physician. Further consultations with a physician may be required if indicated in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D").

3) Criteria for Medical Consultation and Transfer of Primary Responsibility

The Committee recognizes that circumstances may occur throughout the childbearing cycle where there is a deviation from the normal which requires consultation to confirm the presence of the deviation or the transfer of primary responsibility of a client to a physician. These circumstances have been set out in the "Criteria for Medical Consultation and Transfer of Primary Responsibility" which are outlined in Appendix "D". The Committee recommends that these criteria be adopted by the regulatory body which is established to govern midwifery. Further, these criteria should assist in clarifying the role of midwives and physicians in the case of the pregnant woman who seeks primary care from a midwife. These criteria should not be

seen as exhaustive, as other circumstances may arise where the midwife believes a consultation or referral is required. The midwife must have the discretion to refuse to provide primary care and to seek consultation as she determines necessary.

III.

SETTINGS OF PRACTICE

III. SETTINGS OF PRACTICE

RECOMMENDATIONS:

MIDWIFERY PRACTICE SETTINGS

The Committee recommends that:

1) Formal settings for midwifery practice include hospitals, health units, birth centres and other settings which have available the personnel, equipment, resources and systems necessary for safe and effective midwifery care.

2) All midwives, irrespective of their employment situation or primary setting of practice, must be eligible for hospital privileges.

SPECIFIC SETTINGS OF PRACTICE

The Committee recommends that:

1) The feasibility of establishing publicly funded birth centres in Alberta be considered.

HOME BIRTHS

The Committee recommends that:

1) Any woman who may receive care from a midwife as a primary caregiver as determined by the "Criterion for Midwives as Primary Caregivers" (see Chapter II, 4B 1)) have the opportunity to give birth at home under the care of a midwife, provided the woman can be transported within 30 minutes to a hospital capable of dealing with obstetrical emergencies.

2) Midwives who attend home births must have in place a defined back-up system which includes a midwife who can be available to assist at the time of birth, a physician who can be available, if required, at a hospital capable of dealing with the obstetrical emergency, and established links with the emergency service in the community and the Regional Perinatal Service if an emergency occurs.

3) If any of the conditions identified in the "Criteria for Mandatory Transport from the Home Birth Setting" (see Chapter III, Section 3B) arise, the midwife be required to transport the client(s) to a hospital capable of dealing with the obstetrical emergency.

4) A properly designed and implemented prospective study comparing the effectiveness of midwifery care and outcomes of midwife attended births in home and hospital settings be undertaken simultaneously with the introduction of midwifery.

1. MIDWIFERY PRACTICE SETTINGS

In order for midwifery to be successfully integrated into Alberta's health care system, the Committee recommends that the formal settings for midwifery practice should include hospitals, health units, birth centres and other settings which have available the personnel, equipment, resources and systems necessary for safe and effective midwifery care. The Committee believes registered midwives will have the necessary competence to practice in any or all of these settings. In keeping with the principles of consumer choice, autonomous regulated practice and continuity of care, midwives must have legislative authority to practice within the settings that most appropriately meet the needs of their clients in a manner consistent with the standards recommended by this report.

The Committee believes it is essential that, regardless of practice setting, midwives must be able to provide continuity of care and perform their scope of practice as independent primary caregivers. This will occur if programs for the provision of midwifery services are developed in accordance with the "Principles for the Provision and Approval of Midwifery Services" (see Chapter II, Section 2) and the other recommendations in this report.

Moreover, the Committee recommends that all midwives, irrespective of their employment situation or primary setting of practice, must be eligible for hospital privileges. Direct access to resources in hospitals is integral to midwives being able to function as primary caregivers.

In order for hospitals to be in a position to grant hospital privileges to midwives, amendments will be required to legislation governing hospitals in the Province.

2. SPECIFIC SETTINGS OF PRACTICE

A. Hospitals

Virtually all births in Alberta currently take place in hospitals, and the province has an excellent record with respect to outcomes of childbirth for both women and infants. It is likely that most women in Alberta will continue to choose hospitals as their preferred setting for childbirth. The Committee believes the incorporation of midwifery into Alberta's hospital system could enhance the care provided to childbearing women, and that many would choose to be attended by hospital-based midwives if this option became available to them.[9]

B. Health Units

The Committee believes that health units should be considered as a potential setting for provision of midwifery services. However, the Committee sees health units as a location from which midwives may practice, but not where deliveries should occur. Birthing facilities should not be added to health units; accordingly, midwives who choose to practice in health units should maintain hospital privileges or use birth centres or the home setting for intrapartum care.

Within the health unit, midwives would have available the resources and expertise to provide additional support to women if it is required by their unique circumstances. The health unit setting also allows the midwives to focus their practice in the community.

The *Public Health Act* and related Regulation may require amendment to permit this to occur.

C. Birth Centres

Birth centres, situated within hospitals or as "free-standing" centres in the community, have been established in many jurisdictions where midwifery is practised.[10] They are usually staffed by physicians as well as midwives, and situated so as to ensure that childbearing women and infants can be transported quickly to a hospital in the event of an obstetrical emergency. A recent Ottawa-Carleton study showed that 47% of the 577 patients surveyed had a strong interest in alternatives to the traditional hospital setting.[11] Further, in a recent comparative study of "low-risk births" in a hospital and a midwife operated birth centre in the United States, the results showed that the outcomes of labour were similar in both settings, but the use of obstetrical

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[9]Alberta Association of Registered Nurses, Position Paper on Birthing Alternatives, Edmonton, 1991.

[10]Ibid.

[11]Sonderstrom, B., et al. "Interest in alternative birthplaces among women in Ottawa-Carleton", Canadian Medical Association Journal, 142(9): 963-969, 1989.

procedures was significantly lower in the birth centre than in the hospital setting.[12]

The Committee recommends that the feasibility of establishing publicly funded birth centres in Alberta be considered. This will require the collaboration of operators of such facilities, clients, the Government and health care providers.

D. Other Settings

The Committee believes there may be other settings such as an office group practice which could be utilized for the provision of midwifery services. For example, the group practices could consist of a variety of health care providers including physicians and midwives or solely midwives. The midwives in this situation would conduct their practice in a manner similar to physician group practices as they exist at present. Midwives who choose to practice in a group practice should maintain hospital privileges or use birth centres or the home setting for intrapartum care.

Other settings might also be appropriate, as new models of health care delivery emerge in Alberta, such as community health centres, where midwifery practice could form an integral part of the programs offered.

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[12]Feldman, E. and Hurst, M. "Outcomes and procedures in low risk birth: Comparison of hospital and birth centre settings", Birth, 14(1): 18-24, 1987.

3. HOME BIRTHS

Recognizing that women have the right to choose where they give birth, the Committee believes, provided appropriate standards are established, that midwives should be permitted to attend childbirth in women's homes. After a review of information from other jurisdictions, it is the Committee's view that through careful selection of clients and by ensuring midwives meet the standards for registration set out in the report, consumer demand for home births can be met in a safe and effective manner.

This view is supported by the Health Disciplines Board and the Task Force on the Implementation of Midwifery in Ontario, who have stated that there is no substantial evidence that giving birth at home is significantly less safe than giving birth in hospital for appropriately selected and properly attended women. Further, the Health Disciplines Board goes on to acknowledge in its report on midwifery that there are risks associated with home birth, but that these risks could be substantially reduced by ensuring that birth attendants are properly qualified, that criteria and procedures for attending home births are defined and adhered to, and that back-up medical services are pre-arranged.

The Committee agrees with the Health Disciplines Board's statement. In this report, the Committee has outlined qualifications for registered midwives which would ensure that competent midwives will be available to attend home births. Further, in this section of the report, criteria applicable to women who choose planned home birth, and responsibilities for midwives who attend them, are set out.

A. Criteria for Home Birth

The Committee recommends that any woman who may receive care from a midwife as a primary caregiver as determined by the "Criterion for Midwives as Primary Caregivers" (see Chapter II, 4B 1)) have the opportunity to give birth at home under the care of a midwife, provided the woman can be transported within 30 minutes to a hospital capable of dealing with obstetrical emergencies.

Midwives who attend home births must be responsible for having at hand well-maintained equipment, supplies and drugs that may be required during labour, delivery or the postpartum period. Further, the Committee recommends that midwives who attend home births must have in place a defined back-up system which includes a midwife who can be available to assist at the time of birth, a physician who can be available, if required, at a hospital capable of dealing with the obstetrical emergency and established links with the emergency service in the community and the Regional Perinatal Service if an emergency occurs.

Midwives' responsibilities should include advising clients of risks which may arise during the intrapartum stage of pregnancy and the requirement of referral to a physician if any of these problems occur. Further, the client should be informed of the change in the role of the midwife as primary caregiver in a situation where it is no longer possible for the birth to take place in the home setting.

If these criteria are adopted, the Committee believes the home can be a safe alternative for the women who choose this setting to give birth.

B. Criteria for Mandatory Transport from the Home Birth Setting

The Committee believes that, if any of the following conditions occur, a home birth is no longer appropriate and the midwife should be required to transport the client and newborn to a hospital capable of dealing with the obstetrical emergency. Wherever possible, midwives should accompany their clients in transport situations. As this recommendation has implications for other health care providers, there should be collaboration between these providers (such as ambulance services and Regional Perinatal Service) and midwives in the development of appropriate policies to govern this matter.

Therefore, the Committee recommends that midwives be required to transport their clients if any of the following conditions are present:

1) Conditions noted during labour

a) hypertension;
b) anemia (i.e. haemoglobin less than 10 grams/decilitre at onset of labour);
c) proteinuria 2+ or greater and/or other signs of pre-eclampsia;
d) active genital herpes at onset of labour;
e) abnormal labour pattern based on established criteria (e.g. prolonged active or second stages);
f) persistent abnormal presentation;
g) unexplained sudden and severe pain;
h) placenta previa;
i) cord prolapse;
j) fetal distress:
    i) persistent fetal bradycardia; or
    ii) persistent fetal tachycardia;
k) excessive vaginal bleeding;
l) retained placenta with bleeding; and
m) retained placenta without bleeding.

2) Conditions noted postpartum

a) postpartum bleeding unresponsive to therapy;
b) inversion of uterus;
c) lacerations involving the anus, anal sphincter, rectum, urethra or periurethral area; and
d) suspected retained placental fragments or membranes.

3) Conditions noted in the newborn within the first 48 hours

a) respiratory distress (e.g. nasal flaring, grunting, sternal retraction);
b) persistent cyanosis;
c) jaundice;
d) mottling of skin;
e) bruised and/or generalized petechia;
f) obvious congenital anomalies (e.g. omphalocele, spina bifida, cleft palate, etc.);
g) suspected congenital anomalies (e.g. dislocated hip, ambiguous genitalia, etc.); and
h) heart rate less than 100/minute or greater than 160/minute, or any abnormal sounds noted.

C. Monitoring Midwife Attended Home Births

There appears to be no substantial evidence that giving birth at home is significantly less safe than giving birth in hospital for carefully selected and properly attended women. Conversely, however, there is also no conclusive evidence that home birth is as safe as hospital birth.

The Health Disciplines Board noted that the lack of substantial evidence is primarily because research on the topic has been plagued by methodological problems, and presents data that may be relevant only to the particular jurisdiction (e.g. system of obstetrical and midwifery care) from which they were drawn.

The integration of midwifery into Alberta's health care system presents us with an opportunity to rectify this situation. The Committee recommends that a properly designed and implemented prospective study comparing the effectiveness of midwifery care and outcomes of midwife attended births in home and hospital settings be undertaken simultaneously with the introduction of midwifery. This recommendation is discussed further in Chapter VI, Section 5, of the report.

IV.

MIDWIFERY EDUCATION

IV. MIDWIFERY EDUCATION

RECOMMENDATIONS:

EDUCATIONAL QUALIFICATIONS FOR REGISTRATION

The Committee recommends that:

1) To be eligible for registration in Alberta, midwives should have successfully completed a baccalaureate degree program in midwifery that provides the knowledge and skills identified in the "Components of Midwifery Practice" set out in Chapter II, Section 4A, or an equivalent combination of education and experience as determined by the regulatory body established to govern midwifery.

COMPONENTS OF MIDWIFERY EDUCATION

The Committee recommends that:

1) The regulatory body established to govern midwifery be responsible for determining which educational programs adequately prepare midwives for practice in the Province of Alberta.

2) The regulatory body established to govern midwifery utilize the "Components of Midwifery Education" set out in Chapter IV, Section 2A, in making its determination as to which education programs adequately prepare midwives for practice in the Province of Alberta.

ASSESSING CURRENT ALBERTA MIDWIVES

The Committee recommends that:

1) To provide for the registration of current Alberta midwives, a Midwifery Assessment and Upgrading Program be developed in keeping with the principles outlined in the report.

1. EDUCATIONAL QUALIFICATIONS FOR REGISTRATION

The Committee recommends that, to be eligible for registration in Alberta, midwives should have successfully completed a baccalaureate degree program in midwifery that provides the knowledge and skills identified in the "Components of Midwifery Practice" set out in Chapter II, Section 4A, or an equivalent combination of education and experience as determined by the regulatory body established to govern midwifery. A baccalaureate level of academic preparation is consistent with the minimum educational qualifications required for other primary caregivers.

In considering the view that midwives should be required to have prior nursing qualifications, the Committee came to the conclusion that this would not be appropriate for the following reasons:

1) The primary objective in setting basic educational qualifications for registration in Alberta should be to ensure that applicants have the knowledge and skills the Committee has identified as necessary for competent and effective midwifery practice. Many jurisdictions in which midwifery is practiced have established non-nurse midwifery programs that provide this knowledge and skill. It would be unfair to graduates of these programs and unduly costly and restrictive to deny registration to or require extensive upgrading from these individuals simply because they lack nursing qualifications.

2) The quality of practice of nurse and non-nurse midwives (in jurisdictions where both groups practice) appears to be virtually indistinguishable.

3) Although the practices of nurses and midwives overlap to some extent, the Committee believes the scope of practice of nursing and midwifery are sufficiently distinct that there would be little justification for requiring prior nursing qualifications as a prerequisite for registration to practice midwifery.

4) It is desirable that there be portability of credentials and reciprocity of registration in Canada. Ontario has implemented midwifery legislation and education that is not based on prior nursing qualifications, and other Canadian provinces may adopt similar approaches.

In the following three sections, the Committee has set out further recommendations relating to a basic standard of educational preparation for those who wish to register as midwives in Alberta, some principles relating to the development of future educational programs, and a strategy and guidelines for evaluating the competence of current practitioners.

2. COMPONENTS OF MIDWIFERY EDUCATION

At present, midwives in Alberta have a wide variety of educational backgrounds. The same will be true of those who come to Alberta in the future wishing to practice midwifery. Therefore, the Committee recommends that the regulatory body established to govern midwifery should be responsible for determining which educational programs in other countries or provinces adequately prepare midwives for practice in the province. In making this determination, the Committee recommends that the regulatory body utilize the Components of Midwifery Education outlined below as a guideline for carrying out this responsibility. Baccalaureate midwifery, or equivalent programs, which adequately cover the theoretical and technical instruction and practical and clinical experience identified in the "Components of Midwifery Education", should be recognized as basic educational qualifications for registration in this province. These guidelines are consistent with the "Components of Midwifery Practice" in Chapter II, Section 4 A. and with the curricula of midwifery programs in Ontario, the European Community and other comparable jurisdictions.

A. Theoretical and Technical Instruction

1) General

a) basic anatomy and physiology;
b) anatomy, physiology and pathophysiology of pregnancy, including embryology and development of the fetus;
c) bacteriology or microbiology, including laboratory tests and procedures;
d) health assessment;
e) health promotion, health education and preventative health care;
f) nutrition with particular reference to women, newborns and infants;
g) pharmacology related to pregnancy;
h) family studies, cultural influences relating to the childbearing cycle, and women's issues;
i) sex education;
j) well women care and related gynaecology;
k) sociology;
l) psychology;
m) principles and methods of communication, teaching and counselling;
n) principles of decision-making, critical thinking and discriminating judgment;
o) community resources and support programs;
p) health and social services legislation and health care system organization;
q) professional history and development, ethics and legislation;
r) legal issues relevant to midwives, including record keeping, confidentiality and consent;
s) introduction to research;
t) interdisciplinary roles and relationships; and
u) business management.

2) Clinical

a) initial physical assessment of the woman;
b) antepartum, intrapartum and postpartum care;
c) care of the family throughout the childbearing cycle;
d) preparation for childbirth and parenthood, including psychological aspects;
e) psychological and social factors of pregnancy and childbirth, including grief and loss;
f) care of the well and sick newborn, including complications requiring resuscitation of the newborn, and growth and development;
g) analgesia, anaesthesia and resuscitation; and
h) family planning.

B. Practical and Clinical Experience

The practical and clinical experience should be provided in settings which focus on normal childbirth. This experience should be provided under appropriate supervision in a variety of settings. Although the focus of midwifery practice is on normal childbirth, it is necessary to expose students to pregnancies at risk by observing and participating in the care of such women and infants. This experience should provide the students with the required knowledge to identify and assist with high risk pregnancies.

The practical and clinical experience should include:

a) a sufficient number of prenatal examinations and education and counselling of pregnant women;
b) attending 60 births, of which the first 20 may involve the student as an observer or assistant, and 40 must involve the student as primary caregiver, with 30 of these occurring within a program of continuity of care;
c) performing and repairing simple episiotomies and lacerations in keeping with the scope of practice established for the midwife;
d) practical skills such as starting an intravenous infusion, collection of specimens for laboratory tests, aseptic technique, ordering and administering medications including preparation and administration of intramuscular injections, and other skills required to meet the Components of Midwifery Practice;
e) clinical experience in the care of women at risk during the childbearing cycle;
f) supervision and care (including examination) of postnatal women and healthy newborns and infants;
g) observation and care of the newborn requiring special care;
h) certification in neonatal resuscitation; and
i) counselling and teaching experiences.

Clinical experience should take place in as many of the following practice settings as possible:

a) hospitals;
b) health units;
c) the home setting;
d) birthing centres; and
e) other health care facilities and community settings.

3. DEVELOPMENT OF FUTURE EDUCATIONAL PROGRAMS

Although the Committee was not requested to address the establishment of educational programs for midwifery, certain principles arose from the Committee's deliberations which it believes should be incorporated into the development of any future educational programs.

If any basic educational program for midwifery is established in Alberta, it should be approved by the Minister of Advanced Education following consultation with the Minister of Health. The educational program should be established in a public, post secondary educational institution and lead to a baccalaureate degree in midwifery.

The educational program should be designed in a manner which allows midwives to take a core of common subjects with students of other health disciplines such as nursing. As well, clinical and practical experience should be offered in a variety of settings where midwives may eventually practice. These programs should include the subjects identified in the "Components of Midwifery Education" outlined in Section 2 of this chapter. Further, the educational program should be developed in consultation with midwives and other health care providers.

An evaluation of maturity, life experiences and judgment skills should be part of the assessment of each candidate's suitability for the program. The Committee believes many students in the midwifery program will be mature learners and therefore courses must be designed to make them suitable for such learners. Further, where possible, courses should be accessible through a distance delivery system.

Although the faculty for a midwifery education program should be multi-disciplinary, members of the faculty should include practising midwives.

Any education program should be developed in a manner consistent with other midwifery programs in Canada. This would facilitate transferability and reciprocity of registration across Canada.

4. ASSESSING CURRENT ALBERTA MIDWIVES

When professional legislation is introduced to regulate a new profession, standards are set that may not be met by current practitioners. These practitioners can be integrated into the system in a number of ways. One process is conferring the right to practice on all current practitioners without a course of study and with or without assessment. The Committee does not support this option because of the diverse educational backgrounds and experience of current midwives, and the importance of meeting rigorous midwifery standards. The second approach is to require that practitioners attend a full educational program before they can be registered. The Committee believes this option would be unduly demanding and inefficient. The third option is the development of a short course of comprehensive assessment and upgrading (if required) for all current practitioners as a precondition for registration as a midwife. The Committee believes that a time-limited program of comprehensive assessment and upgrading is the most appropriate means for integrating Alberta's midwives into the health care system.

The Committee recommends that a Midwifery Assessment and Upgrading Program be developed in collaboration with the Department of Advanced Education and the Professions and Occupations Bureau to achieve this goal. The purpose of the program would be to assess the current knowledge and skills of Alberta's midwives wishing to become registered and prepare them for registration.

The program would be a primary process for ensuring that registered midwives meet standards which have been established in accordance with the Committee's recommendations. Further, the program should be developed in accordance with the "Components of Midwifery Education" outlined in Section 2 of this chapter. In order to successfully complete the program, and therefore become eligible for registration to practise, all midwives must have the knowledge and skills that are recommended under the "Standards of Midwifery Practice" in Chapter II, Section 4.

The program should be available to current Alberta midwives who have received formal education in midwifery, or have extensive experience as midwives. These persons would undergo an initial assessment to determine:

1) whether they already meet the standards required for registration as a midwife in Alberta and therefore do not need upgrading; or

2) if they do not meet the standards for registration:

    a) whether they have sufficient education or experience to qualify for the upgrading component of the program; and
    b) the upgrading each candidate requires.

The upgrading component of the program would be a one-time opportunity tailored to the needs of each individual candidate. All candidates who are accepted into the program must complete their upgrading and meet the standard within one year of the program being established.

The Committee recommends that the program not be a means for midwives currently residing in other provinces or countries to become registered in the Province of Alberta. Rather, the Committee believes these midwives should meet the newly established Alberta standards for registration from the outset.

The Committee recommends that the following principles underlie the Midwifery Assessment and Upgrading Program:

1) The program be committed to a public process of fair and thorough assessment of Alberta's midwives in order to ensure that only those who practise competently and safely and meet the standards established in accordance with the Committee's recommendations become registered to practise midwifery.

2) The program be specifically targeted for midwives who are residents in Alberta and who have had previous midwifery education and experience.

3) A variety of methods, related to both theory and practice, be used to assess candidates. These methods will take into consideration the value of practical experience and previous learning in diverse settings.

4) That upgrading programs be based on the outcomes of the assessments.

5) The program attempt to accommodate the needs of candidates who are mature and have parental responsibilities or are distant from assessment and upgrading sites.

V.

LEGISLATION REGULATING MIDWIFERY

V. LEGISLATION REGULATING MIDWIFERY

RECOMMENDATIONS:

REGULATION UNDER THE *HEALTH DISCIPLINES ACT*

The Committee recommends that:

1) Midwifery be regulated under the *Health Disciplines Act*.

1. LEGISLATIVE OPTIONS

Three possible legislative options for the regulation of midwifery: the *Nursing Profession Act*, the *Health Disciplines Act* and a "free-standing" Midwifery Act, were considered by the Committee.

In considering the view that midwives should be regulated under the *Nursing Profession Act*, the Committee concluded that this would not be appropriate for the following reasons:

- Midwifery is a profession distinct from nursing, and as such should be separately regulated.

- Midwives and nurses have overlapping but different scopes of practice.

- Some applicants for midwifery registration in Alberta, both initially and in the future, will be graduates of non-nursing midwifery programs that provide the knowledge and skills identified by the Committee as necessary for safe and effective midwifery practice. Because these practitioners are not nurses, they could not be registered under the *Nursing Profession Act*. Regulation of nurse-midwives only, would deny registration to competent midwives, and could make reciprocity of registration between Alberta and other provinces difficult or impossible.

- The Alberta Association of Midwives does not support regulation under the *Nursing Profession Act*.

Free-standing legislation could be an appropriate vehicle for the regulation of midwifery. However, since the mid-1980s, the Government of Alberta's policy has been that new groups of health care practitioners should be regulated under the *Health Disciplines Act*, which provides a common regulatory framework for these emerging professions designed to ensure consistency, collaboration, and accountability. The Committee supports this policy. It should also be noted that the Alberta Association of Midwives did not request free-standing legislation. Instead, it applied for designation and regulation of midwifery under the *Health Disciplines Act*, and the Committee agrees that this is the legislation under which midwifery would most appropriately be regulated.

2. REGULATION UNDER THE *HEALTH DISCIPLINES ACT*

The Committee recommends that midwifery be regulated under the *Health Disciplines Act*. There are significant advantages in regulating midwifery under this legislation. For example, the Act provides for the development of a Midwifery Regulation. Further, governance and discipline can be carried out by a multi-disciplinary committee. A governing committee with representation from the public and affected stakeholders would help facilitate the implementation and acceptance of midwifery throughout the health care system. In time, the Alberta Association of Midwives or some successor organization might assume responsibility for governing the discipline if this transition is warranted.

Secondly, the Health Disciplines Board has experience and expertise in establishing new health professions under the Act's common regulatory framework, and the process has been well supported by other members of the health care system.

The Committee is aware that some organizations view the *Health Disciplines Act* as a structure for regulating disciplines which have less autonomy or status than those regulated by free standing legislation. This is not the Act's purpose, and our recommendation should not be seen in this light. Designation under the Act should not be seen as restricting the autonomy or practices of midwives beyond the parameters of practice recommended in this report and midwives should be regarded as equal members of the health care team.

VI.

IMPLEMENTATION OF MIDWIFERY

VI. IMPLEMENTATION OF MIDWIFERY

RECOMMENDATIONS:

REGULATORY ISSUES

The Committee recommends that:

1) Government proceed as quickly as possible to recognize midwifery and develop a framework for registering midwives and regulating midwifery practice through:

   a) amending the *Health Disciplines Act* during the next session of the Legislative Assembly, to recognize midwifery as a designated discipline under the Act;

   b) establishing a Regulation Development Committee to draft a Midwifery Regulation;

   c) having the Health Disciplines Board coordinate a review of the draft Midwifery Regulation; and

   d) proclaiming the Midwifery Regulation and constituting the Regulation Development Committee as the regulating body responsible for implementing the Regulation and governance of midwifery.

INSTITUTIONAL FACILITIES AND ARRANGEMENTS NECESSARY TO SUPPORT MIDWIFERY PRACTICE IN VARIOUS SETTINGS

The Committee recommends that:

1) Midwifery services must be publicly funded.

2) Methods of remuneration, mechanisms for initial and ongoing assessments of formal midwifery care programs and criteria for future Government funding of the programs should be developed within the concepts and recommendations set out in the report.

3) Midwifery services be integrated into the province's health care system in a manner that does not result in a duplication of services or unnecessary additional costs.

4) Alberta Health play a lead role in facilitating the implementation of midwifery services by establishing appropriate consultation processes to address the implementation issues identified in the report and other issues that may arise as midwifery services are established.

MONITORING THE EFFECTIVENESS OF MIDWIFERY CARE

The Committee recommends that:

1) Processes for monitoring the effectiveness of midwifery care be identified and implemented simultaneously with the introduction of regulated midwifery services in Alberta.

2) The prospective study referred to in Chapter III, Section 3C, be supported by the Government and affected stakeholders have input into its development and access to the results.

1. INTRODUCTION

The principles, scope of practice, standards and approach in the preceding chapters form a sound basis for the implementation of midwifery in Alberta. In its recommendations, the Committee believes it has struck an appropriate balance between the needs and preferences of consumers and public protection and accountability for practice.

However, the Committee recognizes that the actual implementation of midwifery into Alberta's health care system will be a complex task. This concluding chapter identifies some of the major implementation issues that will need to be addressed.

2. REGULATORY ISSUES

The Committee recommends that the Government proceed as quickly as possible to recognize midwifery and develop a framework for registering midwives and regulating midwifery practice through the steps outlined below:

1) Amend the *Health Disciplines Act* during the next session of the Legislative Assembly to recognize midwives as a "designated health discipline" under the Act.

2) Establish (under Section 4.01 of the *Health Disciplines Act*) a Regulation Development Committee to draft a Midwifery Regulation. This committee should be composed of representatives of the public, Alberta Association of Midwives, Government, College of Physicians and Surgeons, Alberta Association of Registered Nurses, Alberta Healthcare Association and Health Unit Association of Alberta.

3) Carry out a review of the draft Midwifery Regulation, coordinated by the Health Disciplines Board in consultation with affected stakeholders.

4) Upon completion of this review, proclaim the Midwifery Regulation and constitute the Regulation Development Committee as the regulatory body responsible for implementing the Regulation and governing midwifery.

3. COLLABORATION BETWEEN MIDWIVES AND OTHER HEALTH CARE PROVIDERS

All participants in the health care system must fully accept and cooperate with midwives if midwifery is to be successfully incorporated into Alberta's health care system. The Committee believes that such cooperation is possible if clearly understood expectations and arrangements for collaboration between midwives and other health care providers are developed and professional and legal responsibilities are defined.

The Committee understands that other health care providers may have concerns about the introduction of midwifery. However, it believes that these health care providers share the same broad objective - a maternity care system that is responsive to consumer needs and ensures high standards and quality care. The Committee believes its recommendations will ensure this objective is achieved, and that these stakeholders will support our approach if they have the opportunity to participate in the implementation of midwifery.

The Committee does not wish to downplay the important issues that have surrounded inter-professional relationships and incorporation of midwifery in the health care system. Many of these issues arise from the potential overlaps between the practices of midwives and those of other practitioners such as physicians and nurses. However, the Committee believes these potential difficulties can be resolved by adherence on everyone's part to defined roles and protocols, and a willingness to respect each other's roles in the best interests of consumers.

The Government can do much to facilitate this acceptance and cooperation by conferring legislative recognition on midwifery, and by developing specific mechanisms to promote collaboration. Firstly, the Committee believes that the multi-disciplinary committee referred to in Section 2 of this chapter would become a focal point of collaboration and cooperation regarding the implementation of midwifery. A multi-disciplinary approach would involve affected stakeholders in the process of establishing midwifery in Alberta from the outset. Through working together, the Committee believes the different groups would come to understand each other's concerns and work cooperatively to address them.

The Committee believes that cooperation and collaboration can also be encouraged by:

1) allowing midwives to participate in existing organizations concerned with maternity care such as the Alberta Perinatal Program Advisory Committee;

2) involving physicians, nurses, hospital administrators and others in all decisions relating to the implementation of midwifery; and

3) creating opportunities for midwives and practitioners, such as physicians and nurses, to collaborate with each other in practice in a range of settings and situations.

4) encouraging midwives to utilize existing assessment tools such as the risk scoring system, developed by the Alberta Medical Association Committee on Reproductive Care, in conjunction with the more comprehensive "Criteria for Medical Consultation and Transfer of Primary Responsibility" (see Appendix "D") recommended in this report.

4. INSTITUTIONAL FACILITIES AND ARRANGEMENTS NECESSARY TO SUPPORT MIDWIFERY PRACTICE IN VARIOUS SETTINGS

The implementation of midwifery, in accordance with the scope and standards of practice recommended by the Committee, would have important implications for the health care system in Alberta. For example, all midwives must have access to hospital facilities, whether or not hospitals are their primary practice setting, and regional perinatal services for consultation and direct referral of childbearing women and infants as required. Midwives must be able to consult effectively and efficiently with physicians and other health care providers, and collaborate with local ambulance operators and attendants to ensure that emergency support is available if needed.

Changes will be required to ensure that the institutional facilities and arrangements necessary to support midwifery practice in various settings will be in place. For example, amendments to existing legislation, such as the *Hospitals Act*, the *Public Health Act* and *Narcotic Control Act*, may be necessary to ensure the development of midwifery as an autonomous, primary care practice.

Methods of payment for midwifery services and the employment status of midwives will also be important issues. It is not within the Committee's mandate to propose a model of remuneration for midwives. However, the Committee recommends that midwifery services must be publicly funded. The Committee also recommends that methods of remuneration, mechanisms for initial and ongoing assessments of formal midwifery care programs and criteria for future Government funding of the programs should be developed within the concepts and recommendations set out in the report.

With regard to employment status, the Committee believes it should be possible for midwives to be employees of or enter into contractual arrangements with hospitals, health units, or other health facilities or programs, or become partners in office group practices with other health care providers. Whatever employment models are adopted, working conditions should be reasonable, and midwives should be fairly remunerated in a manner that is consistent with their level of responsibility, demands on their time, difficulty of their work, continuing education activities and professional liability insurance.

The administrative and financial arrangements necessary to establish midwifery service require review. New and innovative mechanisms and programs may be required to facilitate the establishment of midwifery services.

Further, the Committee believes that midwifery care can and should be cost effective. The Committee recommends that midwifery services be integrated into the province's health care system in a manner that does not result in duplication of services or unnecessary additional costs. Initially, additional monies may be required for start-up-costs related to establishing midwifery services and the Midwifery Assessment and Upgrading Program. As the Committee is mindful of the limited economic resources of the Government, it suggests that midwifery services be funded, whenever possible, through a reallocation of monies already budgeted for the health care system. The Committee believes that once midwifery services are established, there should be

a savings of monies in other areas of the health care system which could be utilized for funding midwifery services.

Along with these principles and general recommendations, the Committee recommends that Alberta Health play the lead role in facilitating the implementation of midwifery services by establishing appropriate consultation processes with midwives and other appropriate stakeholders, including the public, to address such issues as the funding of midwifery services, modes of remuneration for midwives, creative and innovative approaches to incorporating midwifery services into settings such as hospitals and health units, and any other issues that may arise as midwifery services are established.

5. MONITORING THE EFFECTIVENESS OF MIDWIFERY CARE

The Committee recommends that processes for monitoring the effectiveness of midwifery care be identified and implemented simultaneously with the introduction of regulated midwifery services in Alberta. These processes may take a number of forms. For example, the midwifery governing committee would monitor the conduct and competence of midwives through the regulatory system established under the *Health Disciplines Act*. Individual midwives should have opportunities to engage in continuing education and peer review to maintain their competence, to consult with other midwives, and to have structured opportunities to review cases. Midwives collectively should develop programs as other professions have done, to continuously monitor their effectiveness in terms of intervention, morbidity and mortality rates, and client satisfaction.

The prospective study, referred to in Chapter III, Section 3C, to compare the outcomes of midwife attended births in home and hospital settings, would also be an important mechanism for monitoring the effectiveness of midwifery care. In addition to promoting a high degree of practitioner accountability, the results of such a study would provide invaluable information for guiding the development of policies and standards. The Committee recommends that the study be supported by Government and that affected stakeholders have input into its development and access to the results. If feasible, the study should be done in collaboration with other Canadian jurisdictions which implement and regulate midwifery services in a manner similar to Alberta.

APPENDIXES

Appendix "A"

Documents Utilized by the Midwifery Services Review Committee in its Deliberations

In addition to the documents footnoted in the report, the Committee also considered the following:

Advisory Committee to the Arizona Midwife Licensing Program. Guidelines for Clinical Practice in Midwifery, Arizona: Office of Maternal and Child Health, Department of Health Services, 1985.

Alberta Association of Midwives, Standards of Practice, May 1988.

College of Physicians and Surgeons of Manitoba and Manitoba Association of Registered Nurses, Report on the Future Role of Midwifery in Manitoba, Winnipeg, Ministry of Health, February 1991.

Council of the European Communities, "Training Program for Midwives", Official Journal of the European Communities, L33, Vol. 23, Luxembourg: Office for Official Publications of the European Communities, 1980.

Curriculum Design Committee on the Development of Midwifery Education in Ontario, Report of the Curriculum Design Committee on the Development of Midwifery Education in Ontario, Toronto: Minister of Health, 1990.

Government of Ontario, Ministry of Health. "Bill 56", An Act respecting the regulation of the Profession of Midwifery, Toronto: Legislative Assembly of Ontario, 1991.

Kaufman, Karyn J., "The Introduction of Midwifery in Ontario", Birth, 18: 2, June 1991.

Kloosterman, G.J., "List of medical indications for specialist care during pregnancy, labour and the puerperium in the Netherlands", Report of the Task Force on the Implementation of Midwifery in Ontario, 1977.

Interim Regulatory Council on Midwifery, "Core Competencies: A Foundation for Midwifery Education", "Laboratory Testing and Diagnostic Imaging" and "Indications for Mandatory Consultation and Transfer of Care", Toronto, 1991.

Midwifery Integration Planning Report, Report of the Midwifery Integration Planning Project, Toronto, Interim Regulatory Council on Midwifery, 1991.

Ontario Task Force on the Implementation of Midwifery (Mary Eberts, Chairperson), Report of the Task Force on the Implementation of Midwifery in Ontario, Toronto: Ministry of Health,

Government of Ontario, 1987.

The Committee also reviewed the following videos of home birth in Holland:

"Look, A Baby"; and

"Under Her Own Steam".

Appendix "B"

Drugs Prescribed and Administered by Registered Midwives

Drugs which can be independently prescribed and administered by the registered midwife:

1) **Antepartum:**

		Route
a)	Vitamins and Minerals	Oral
b)	Anti fungal agents: Nystatin, Immidazoles e.g. Canesten, Ecostatin	Local
c)	Anti haemorrhoidal agents: e.g. Protocedyl	Local
d)	Treatment for constipation: - bulk formers - suppositories	 Oral Rectal

2) **Intrapartum:**

		Route
a)	Analgesic: Meperidine (Demerol)[13] 75-100 mg, limited to 2 doses 4 hours apart	Intramuscular
b)	Antiemetic: Dimenhydrinate (Gravol) 25-50 mg Q3-4 hourly	Intramuscular
c)	Promethazine (Phenergan) 25 mg 4 hr prn	Intramuscular
d)	Entonox	Inhalant

[13]It is highly recommended that an amendment be sought to the *Narcotic Control Act* which would allow a registered midwife to prescribe meperidine and acetaminophen with codeine. In the interim, there should be collaboration whereby the physician would prescribe these drugs within the parameters outlined in Appendix "B".

3) Postpartum:

		Route
a)	Oxytocin - 5 Unit bolus	Intramuscular
b)	Ergometrine - 0.25 mg x 3 doses total	Oral/Intramuscular
c)	Acetaminophen with codeine[14] (30 mg)/ASA with codeine (30 mg)	Oral

4) Neonate:

		Route
a)	Naloxone (Narcan) 0.1 mg/kg	Intramuscular
b)	Erythromycin Ophthalmic ointment	Local
c)	Vitamin K - 1 mg phytonadoine	Intramuscular
d)	Epinephrine - 1:10,000 solution, 0.1 ml/kg	Intramuscular
e)	Dextrose - 10% solution, 2 ml/kg	Intravenous
f)	Oxygen	Inhalant

5) Other:

		Route
a)	Magnesium sulfate	Intravenous/Intramuscular
b)	Hydralazine	Intravenous/Intramuscular
c)	Normal Saline or Ringer's solution	Intravenous
d)	Oxygen	Inhalant

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[14]See footnote 13.

Appendix "C"

Screening and Diagnostic Tests

1) **For the client:**

   a) **chemistry:** blood glucose

   b) **cytology:** cervical smears (Pap smears)

   c) **haematology:** haemoglobin, haematocrit, white blood cell count, differential, platelet count, red blood cell morphology

   d) **microbiology:** cervical and vaginal cultures (including sensitivities where relevant) for group B streptococcus, gonorrhoea, chlamydia, yeasts, trichomonas, and gardenereila; urine for culture and sensitivities; swabs for culture and sensitivities (eg. wounds, episiotomies); viral swabs (herpes)

   e) **serology/immunology:** pregnancy tests (blood and urine), blood group and type with antibody screen, repeat antibody testing, hepatitis B antigen, human immunodeficiency virus antibody, rubella antibody, toxoplasmosis antibody, syphilis serology, cytomegalo virus antibody

   f) **ultrasound:** obstetrical for diagnostic purposes only

   g) **urine:** routine and microscopic urinalysis

2) **For the newborn:**

   a) haemoglobin, haematocrit, white blood cell count with differential, phenylketonuria, thyroid screening, glucose, coombs and bilirubin

Appendix "D"

Criteria for Medical Consultation and Transfer of Primary Responsibility

Definitions

1. **"Consult"** means that conditions exist that require assessment, diagnosis, and/or clinical intervention by a physician (e.g. obstetrician, neonatologist, paediatrician, psychiatrist, family physician, etc.). In all circumstances, consultation should require direct evaluation of the client by the consultant. A written report of the results of the consultation should be made available to the midwife and, when indicated, the midwife should discuss management directly with the consultant. The decision to transfer primary responsibility must be made if the results of consultations so indicate.

2. **"Transfer"** means management of the client by the midwife as primary caregiver must be transferred to an appropriate physician. The midwife should remain with the client, if needed, to provide information to the physician and to offer support to the client. The midwife should continue to be involved in the ongoing care of the client to the extent determined jointly by the client, the physician and the midwife.

The circumstances the Committee has identified as requiring either a consultation or transfer to a physician are outlined below. These criteria should be reviewed from time to time to ensure they are relevant, and ensure that safe care is provided to the woman during the childbearing cycle.

Assessment and Management

	Consult	Transfer
1) Initial interview		
a) History of two or more consecutive premature labours, or history of low birth weight infant(s) (less than 2500 grams)	X	
b) Previous operations or injuries to the uterus or vagina (e.g. operations for prolapse, cervical conization, myomectomy, vesicovaginal and recto-vaginal fistulae, classical cesarean section, etc.)		X

		Consult	Transfer
c)	Previous low segment cesarean section	X*	
d)	Previous stillbirth or neonatal loss	X	
e)	Congenital defect(s) of the reproductive organs	X	
f)	Psychiatric illness requiring hospitalization and/or psychotherapeutic drugs	X	
g)	Serious chronic or acute medical conditions (e.g. diabetes, cardiac disease, renal disease, hepatitis, tuberculosis, etc.)		X
h)	Severe mental disability	X	
i)	Vaginal bleeding this pregnancy	X	
j)	Severe pre-eclampsia or eclampsia during previous pregnancy	X	
k)	Rh negative antibody titre positive		X
l)	Active sexually transmitted disease or known HIV positive		X
m)	Significant use of drugs or alcohol	X	
n)	Suspected or diagnosed congenital anomaly that may require immediate medical management after delivery	X	
o)	Previous difficult vaginal delivery	X*	
p)	Parity greater than 4	X	
q)	Severe postpartum hemorrhage	X	
r)	Previous infant(s) larger than 4500 grams	X	
s)	Marked skeletal abnormalities in pregnant women	X	
t)	Initiated prenatal care after 28 weeks gestation	X	

*** Consultation subject to the midwife first reviewing the obstetrical history and other relevant records to determine if consultation is required.**

		Consult	Transfer
2)	**Conditions noted during pregnancy**		
a)	Early in pregnancy (i.e. up to 20 weeks gestation)		
i)	Serious medical conditions (i.e. diabetes, cardiac disease, renal disease, etc.)		X
ii)	Abnormal Pap smear	X	
iii)	First trimester bleeding and/or unexplained, persistent abdominal pain	X	
iv)	Abnormal fetal growth pattern	X	
v)	Hyperemesis		X
vi)	Exposure to known teratogens	X	
vii)	Persistent abuse of drugs or alcohol	X	
viii)	Haemoglobin less than 9 grams/decilitre	X	
ix)	Active sexually transmitted diseases or known HIV positive		X
x)	Viral infection with fever first trimester	X	
b)	Late in pregnancy (i.e. after 20 weeks gestation)		
i)	Vaginal bleeding	X	
ii)	Pregnancy induced hypertension above 30 mm. Hg systolic and/or 15 mm. Hg diastolic (2 readings 6 hours apart), or persistent blood pressure over 140/90 mm Hg		X
iii)	Polyhydramnios or oligohydramnios		X
iv)	Antepartum fetal death		X
v)	Thromboembolic disease		X
vi)	Severe varicosities of either the vulva or lower extremities	X	

		Consult	Transfer
vii)	Abnormal fundal growth pattern	X	
viii)	Persistent anemia (i.e. haemoglobin less than 10 grams/decilitre)	X	
ix)	Persistent abnormal presentation after 36 weeks		X
x)	Documented postdate pregnancy greater than 42 weeks gestation	X	
xi)	Active genital herpes		X
xii)	Rh isoimmunization or other positive antibody screen		X
xiii)	Premature labor		X
xiv)	Prolonged rupture of membranes	X	
xv)	Premature rupture of membranes at term greater than 12 hours without onset of labor	X	
xvi)	Multiple gestation		X
xvii)	Acute pyelonephritis		X
xviii)	Weight gain less than 4500 grams at term	X	
3) Conditions noted during labor			
a)	Excessive vaginal bleeding		X
b)	Cord prolapse		X
c)	Fetal distress:		
i)	Persistent fetal bradycardia		X
ii)	Persistent fetal tachycardia		X
d)	Abnormal labor pattern based on established criteria:		
i)	Prolonged active stage	X	

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ii) Prolonged second stage	X	
e) Retained placenta with bleeding		X
f) Retained placenta without bleeding	X	
g) Fever greater than 38°C		X
h) Abnormal presentation		X
i) Hypertension		X
j) Proteinuria 2+ or greater and/or other signs of pre-eclampsia		X
k) Presence of meconium at any time during labor	X	
l) Ketonuria (more than 4 hours or non-responsive to treatment)	X	
m) Persistent vomiting and/or diarrhea	X	
n) Unexplained sudden and severe pain	X	
o) Inability to cope with pain during labor	X	
4) Conditions noted postpartum		
a) Postpartum hemorrhage		X
b) Inversion of uterus		X
c) Lacerations involving the anus, anal sphincter, rectum, urethra or periurethral area		X
d) Suspected retained placenta fragments or membranes	X	
e) Persistent bladder dysfunction after delivery	X	
f) Signs of puerperal infection	X	
g) Serious psychological problems	X	
h) Persistent uterine atony	X	

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i) Abnormal uterine sub-involution	X	
j) Suspicion of superficial or deep venous thrombophlebitis	X	
k) Signs of breast infection	X	
l) Late postpartum hemorrhage	X	
m) Unexplained persistent chest pain or dyspnea		X
5) Conditions noted in newborn and infant		
a) Immediately after delivery		
i) Apgar score less than 5 at one minute and/or less than 7 at 5 minutes	X	
ii) Respiratory distress (e.g. nasal flaring, grunting, sternal retraction)		X
iii) Persistent cyanosis		X
iv) Pallor	X	
v) Abnormally flushed, or ruddy color	X	
vi) Jaundice		X
vii) Mottling of skin		X
viii) Abnormal pigmentation	X	
ix) Bruised and/or generalized petechia		X
x) Meconium staining of infant's skin	X	
xi) Single umbilical artery	X	
xii) Lethargic, flaccid or unresponsive to stimulation	X	
xiii) Weight less than 2500 grams or greater than 4500 grams	X	
xiv) Postmaturity syndrome	X	

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xv)	Shrill or abnormal cry	X	
xvi)	Difficulty in feeding (e.g. poor sucking, vomiting, choking, etc.)	X	
xvii)	Obvious congenital anomalies (e.g. omphalocele spina bifida, cleft palate, etc.)		X
xviii)	Suspected congenital anomalies (e.g. dislocated hip, ambiguous genitalia, etc.)		X
xix)	Heart rate less than 100/minute or greater than 160/minute, or any abnormal sounds noted		X
b)	During postpartum and follow-up periods		
i)	Does not urinate within 12 hours		X
ii)	Does not pass meconium within first 24 hours	X	
iii)	Unstable temperature above or <u>below</u> the normal (36.8°C)	X	
iv)	Persistent, quiet tachypnea beyond the first four hours of life (i.e. respiration rate 60/minute)		X
v)	Scaphoid abdomen associated with respiratory distress		X
vi)	Red umbilicus or oozing from the cord		X
vii)	Presence of persistent rash or vesicles, etc. on skin and/or mucus membranes	X	
viii)	Progressive jaundice	X	
ix)	Fever unresponsive to therapy	X	
x)	Abnormal movement of any extremity	X	
xi)	Skeletal deformities (e.g. talipes (clubfoot) etc.)	X	
xii)	Tremors, twitching, hyperactivity, seizures, staring or eye-rolling		X

		Consult	Transfer
xiii)	Abnormal abdominal distention		X
xiv)	Infant above the ninetieth percentile or below the tenth percentile for weight, length or head circumference	X	
xv)	Weight loss in infant greater than 12% of birth weight	X	
xvi)	Failure of infant to regain birth weight within three weeks	X	
xvii)	Feeding intolerance with vomiting or diarrhea	X	
xviii)	Conditions that cause concern in either the parents or the midwife	X	

DEFINITIONS

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"Alberta midwife" means a person who has:

a) actively practised midwifery in Alberta for at least two years, one of which has been as a primary caregiver and, provided further, that such experience was within the last six years; or

b) midwifery qualifications from another country and has been actively involved in providing maternity care in Alberta for at least one year during the two years immediately preceding the Midwifery Assessment and Upgrading Program; or

c) registered nurse qualifications and some formal midwifery training and has been actively involved in providing maternity care in Alberta during the two years immediately preceding the Midwifery Assessment and Upgrading Program; or

d) midwifery qualifications from another country, who is a resident in Alberta at the time the announcement is made for the establishment of the Midwifery Assessment and Upgrading Program, and has actively practiced midwifery for at least two years within the last six years.

"antepartum or antenatal" means the time from conception to birth.

"attend" means to be present during labour and at the time of birth.

"childbearing cycle" means the period from conception to the end of the postpartum period, generally regarded as six weeks past birth.

"client" means a woman, and following birth her newborn, who seeks primary care from a midwife.

"community health centre" means a community resource serviced by health care professionals, which may include physicians, nurses, midwives, dietitians, social workers.

"community resources" means programs or organizations in the community which are available to provide information and assistance to the family in the childbearing cycle.

"diagnostic tests" means the use of relevant tests to identify conditions that may be detrimental to the pregnancy.

"drugs" includes any substance or mixture of substances manufactured, sold or represented for use in

(a) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof, in man, or

(b) restoring, correcting or modifying organic functions in man.

"examination" means inspection or investigation to aid in making a diagnosis.

"health care provider" means any individual who provides health services to health care consumers.

"infant" means the newborn after 28 days of age.

"intrapartum care" means care during labour.

"midwife" means a person who has the requisite qualifications to be registered to practice midwifery.

"mother" means the client after delivery of the newborn.

"newborn" means the baby from the moment of birth to 28 days of age.

"normal pregnancy" means a healthy pregnancy in which no recognized complication is likely to occur.

"obstetrical procedure and intervention" means any necessary procedure or actions taken to prevent or correct recognized pathology in pregnancy, labour, birth and postpartum.

"para" means the number of pregnancies in which an infant of more than 20 weeks gestation was delivered (whether alive or dead).

"parity" means the number of live or stillborn infants of more than 20 weeks gestation that a woman has delivered.

"perinatal" means of or pertaining to the time and process of being born.

"postpartum" means the time after giving birth, usually considered to be up to six weeks post birth.

"primary caregiver" means a health care practitioner who is the first point of entry for provision of health services. The primary caregiver functions without supervision and can make autonomous decisions with full professional and legal responsibility for the care he/she provides.

"Regional Perinatal Service" means the service provided in Alberta linking consultants in tertiary care centres with health care providers in regional and community hospitals.

"routine screening" means the use of tests and procedures recognized as necessary in establishing the health status of a pregnant woman.

"woman" means, in the context of this report, the client during the antepartum and intrapartum stages of the childbearing cycle.